

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07032

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Pruss Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Penna</u> COUNTY <u>Phila</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ludersville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75X-3</u>		STREET ADDRESS <u>75X-3</u>	
3. NAME OF DECEASED (First) <u>Lincoln</u> (Middle) <u>Babunsky</u> (Last) <u>Babunsky</u>	4. DATE OF DEATH (Month) <u>July</u> (Day) <u>10</u> (Year) <u>1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year: Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lincoln</u>		14. MOTHER'S MAIDEN NAME <u>Lincoln</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>24</u>	
17. INFORMANT <u>Peter Babunsky, Sutersville, Pa.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>450.1 Cardiac Dilatation</u>		
Antecedent cause(s) (b) <u>General Asthma & Pulmonary Emphysema</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Smoking of Left Foot</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>7/6</u>	19b. MAJOR FINDINGS OF OPERATION <u>General Emphysema of Left Foot</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>22</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7/6</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 20, 1955, to July 6, 1955, that I last saw the deceased alive on July 20, 1955, and that death occurred at 3:53 P.M. from the causes and on the date stated above.

SIGNATURE <u>C. R. White</u>	(Degree or title)	ADDRESS <u>Ludersville, Pa.</u>	DATE SIGNED <u>7/6/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>July 9</u>	NAME OF CEMETERY OR CREMATORY <u>Edgar's</u>	LOCATION (City, town, or county) <u>Edgar's</u>
DATE REC'D BY LOCAL REG. <u>July 6</u>	REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>	ADDRESS <u>Church Hill, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1955

BUREAU V. S.

Bakanowsky

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

Items 1,9, Film G186 9-8-55 et

1. PLACE OF DEATH: COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Ind</u> COUNTY <u>8. a.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Stevensville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Ezekiel</u> (First) (Middle) (Last) <u>Emory</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 12 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>About 85</u> yrs.
9. AGE last birthday <u>85</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Ind</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Lucille Rich</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause		<u>Cerebral hemorrhage</u> <u>July 12, 1955</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>Arteriosclerosis general + cerebral</u> <u>5 years</u>	
		<u>Hypertensive cardio-vascular disease</u> <u>3 years</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input type="checkbox"/> <u>No</u> <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> , to <u>July 12, 1955</u> , that I last saw the deceased alive on <u>July 11, 1955</u> ; and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Theodor Sattelmair M.D.</u>		ADDRESS <u>Stevensville</u> DATE SIGNED <u>July 14, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>July 14, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Stevensville (Col.)</u> LOCATION (City, town, or county) (State) <u>Stevensville Ind</u>	
DATE REC'D BY LOCAL REG. <u>July 15, 55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth Hoster</u> 24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill Ind</u>	

F. B. BUREAU

JUL 19 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7034
Item 22 Film G184 8-9-55 ams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07034

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen Anne
City or town X Centerville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Queen Anne
City or town Centerville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Mary Matilda Fisher

3.(b) Social Security Number

4. Sex Female 5. Color or race wh 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife Perry Fisher

7. Birth date of deceased (mo., day, yr.) June 1 - 1853 8.(c) If alive, give age _____ years

8. AGE: Years 102 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Storr Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joe Carter

13. Birthplace Md -

14. Maiden name Don't know.

15. Birthplace Don't know.

16. Informant Hewrietta Fisher (daughter)
Address Centerville Md

17. Burial Date thereof July 25 - 55
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Chertee Field

Location Centerville
Funeral director James B. Washell
Address Easton

18. 7-23 19-55 Elie Armstrong
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 55 at 4:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 19 55 to July 22 19 55

and that I last saw him alive on July 21 19 55

Immediate cause of death Fracture of hip
caused by a fall

Due to

Due to

Other conditions 904.0

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 4PM
Accident, suicide, or homicide Accident Date of 7-16-55

Where did injury occur? X HOME (City or town) (County) 17 (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell in her bedroom Injured at work?

23. SIGNATURE W. Henry Fisher
Address Centerville Md M. D. or other 7/25-55
Date signed

RECEIVED
AUG 3 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 8 & 9: Film G184
8/5/55 dmr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		MARYLAND LENGTH OF STAY (In this place)		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>g.a.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>Henry</u> (Middle) <u>Norman</u> (Last) <u>Gardner</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>12-15-1901</u> 9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Gardner</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-9956</u>		17. INFORMANT AND ADDRESS <u>Mrs. Norman Gardner - Chester</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Acute myocardial infarction</u>					1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Coronary Thrombosis</u>					1 hr.
(c) <u>Hypertensive cardiovascular disease</u>					4 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>July 13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 7</u> , 19 <u>55</u> , and that death occurred at <u>8:30 A.</u> m., from the causes and on the date stated above.					
SIGNATURE: <u>G. Wm. Martin, Jr. MD</u>		(Degree or title)		ADDRESS <u>Queencstown, Md.</u> DATE SIGNED <u>7/16/55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 16</u>		NAME OF CEMETERY OR CREMATORY <u>Stevensville</u> LOCATION (City, town, or county) <u>Stevensville</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-16</u>		REGISTRAR'S SIGNATURE <u>Elizabeth Hopton</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane - Church Hill, Md.</u> ADDRESS	

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JUL 25 1955

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07036
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 252

1. PLACE OF DEATH: COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Penn</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Centerville</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>614 Penn St. Chester Penn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>75X-3</u> ✓	
3. NAME OF DECEASED: (Type or Print) <u>Helen Elizabeth Middleton</u>		4. DATE OF DEATH <u>July 7</u> 19 <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Nov 14 - 1914</u>
9. AGE last birthday: <u>40</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>Centerville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>Wilton Daniel Sparks</u>		14. MOTHER'S MAIDEN NAME: <u>Nellie Tester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>173-10-7357</u>	
17. INFORMANT & ADDRESS: <u>Nellie Tester Sparks - mother Centerville Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary occlusion (Sudden)</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>W. Henry Foster</u> <u>Centerville Md</u> CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>7-7-55</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>July 11 - 55</u>	NAME OF CEMETERY OR CREMATORY <u>Chester Rural</u>
LOCATION (City, town, or county) (State) <u>Chester Pa</u>	24. FUNERAL DIRECTOR <u>Barton Bros Centerville Md</u>	ADDRESS
DATE REC'D BY LOCAL REG. <u>7-8-55</u>	REGISTRAR'S SIGNATURE <u>Oliver Armstrong</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1965

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07038

7037

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Inson Anne</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>on farm near Bennetts Pt.</u>		STREET ADDRESS (If rural, give location) <u>2 a Co Rd</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Edgar</u> (Middle) <u>Raymond</u> (Last) <u>Marion</u>		(Month) <u>July</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
			<u>Oct 16 - 1902</u>
9. AGE last birthday <u>52</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Chauffeur</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>Philip Marion</u>	14. MOTHER'S MAIDEN NAME <u>Marion Mc Mathew</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY No. <u>no</u>	17. INFORMANT AND ADDRESS <u>Wm. V. Morris - 1527 N. Carey St</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>341X</u> <u>Coronary occlusion - he had asthma for last</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(b) <u>2 1/2 yrs</u> <u>He died following a heart attack while working</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>on a farm near Bennetts Pt. - 2 a Co Rd</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. H. Fisher M. D. Centerville Md Deputy Med. Examiner 2 a 3 rd 7/4/55

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

Burial July 7, 1955 MT. Aetna Cemetery Baltimore, Maryland

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE ADDRESS

7-8-55 Adm. Hedrick Joseph L. Russ 2222 W. North Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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113

Re. L. V. 112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07039

CERTIFICATE OF DEATH

Reg. Dist. No. 254

Item 11,12 FilmG184 8-8-55 e+

1. PLACE OF DEATH- COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Queenstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Hattie</u> (Middle) <u>Ellen</u> (Last) <u>Poet</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 9 - 1875</u>
9. AGE last birthday <u>80</u> yrs.		10. UNDER 1 year Months <u>8</u> Days <u>25</u> Hours <u>19</u> Mins. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Charles B. Poet Queenstown Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Circulatory collapse</u>			<u>2 min.</u>
Antecedent cause(s) (b) <u>Heat prostration</u>			<u>1 day.</u>
Disease or condition, if any, giving rise to the above cause stating the underlying cause last (c) <u>Myocardial insufficiency</u>			<u>6 mos.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 31, 1955</u> to <u>July 25, 1955</u> , that I last saw the deceased alive on <u>July 25, 1955</u> , and that death occurred at <u>8:10 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>G.W. Martin, Jr. M.D.</u>		ADDRESS <u>Queenstown, Md.</u> DATE SIGNED <u>July 25, 1955</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>July 28-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
DATE REC'D BY LOCAL REG. <u>July 28-55</u>		24. FUNERAL DIRECTOR <u>Edgar L. Lane Church Hill</u>	
REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07040

CERTIFICATE OF DEATH

Reg. Dist. No. 252

Item 4. Film G184 8-9-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Waynes</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write OR and give nearest town) <u>Centerville</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		OR <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>MILTON</u> (Middle) <u>W</u> (Last) <u>SENEY</u>				July 21, 1955			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>June 11-1896</u>	
9. AGE last birthday: <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Owner</u>		11. BIRTHPLACE (State or foreign country): <u>in Centerville Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Samuel W Senev</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie Kuntz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW#1</u>				16. SOCIAL SECURITY No.: <u>217-01-1799</u>			
17. INFORMANT & ADDRESS: <u>Lee Senev, Pseudtown Md</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.1 Immediate cause (a) <u>Coronary Occlusion</u>							
Antecedent cause(s) (b) <u>Found dead in bed</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>6/30</u> , 19 <u>55</u> , to <u>7/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>55</u> , and that death occurred at <u>4:20</u> a.m., from the causes and on the date stated above.							
SIGNATURE		(DEGREE OR TITLE)		ADDRESS		DATE SIGNED	
<u>W. Stevery Foster</u>		<u>M.D.</u>		<u>Centerville Md</u>		<u>7/22-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF: <u>July 23-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Church Hill</u>		LOCATION (City, town, or county) (State): <u>Church Hill Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-22-55</u>		<u>Chie Ametrang</u>		<u>Barton Bros. Centerville Md</u>			

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7-40 1th 8,9, Film G184 7-22-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Queen Anne's</i>	MARYLAND	STATE <i>md.</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <i>Barclay</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Massey</i>	<i>14X-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>08</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<i>JOHN O. SHELTON Sr.</i>		<i>July 14 1955</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <i>Aug 7, 1874</i>
9. AGE last birthday: <i>81 1/2</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Tenant Farmer</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>John Shelton</i>		14. MOTHER'S M maiden NAME: <i>Clydebeth Paly</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <i>Mrs Nelson Hill Dover Del.</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>Cerebral Hemorrhage</i>			
DUE TO			
(B) <i>Cerebral Arteriosclerosis</i>			
DUE TO			
(C) <i>Chronic Hypertension</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Pneumonia</i>			
19A. DATE OF OPERATION: <i>no</i>		19B. MAJOR FINDINGS OF OPERATION: <i>no</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>no</i>		21F. HOW DID INJURY OCCUR?	
21G. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <i>June 22, 1955</i> , to <i>July 14, 1955</i> , that I last saw the deceased alive on <i>July 13, 1955</i> , and that death occurred at <i>837 A.M.</i> from the causes and on the date stated above.			
SIGNATURE: <i>W. A. McKittrick</i>		DATE SIGNED: <i>July 15/55</i>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF	
<i>Burial</i>		<i>July 17/1955</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Massey Cem.</i>		<i>Massey md.</i>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<i>7-17</i>		<i>Edgar L. Dore</i>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<i>Edgar L. Dore</i>		<i>Edward Wilbur Millington md.</i>	

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MARYLAND

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>Queen Ann C.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Barclay</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Barclay P.O. Box 144</u>		STREET ADDRESS (If rural, give location) <u>P.O. Box 144</u>	
3. NAME OF DECEASED (Type or Print) <u>Johnson</u> (First) <u>de Roy</u> (Middle) <u>Wilson</u> (Last)		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>M.</u> COLOR OR RACE <u>C.</u>		6. DATE OF BIRTH <u>March 16, 1915</u> 40 yrs.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. AGE last birthday <u>40</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saline</u>		11. BIRTHPLACE (State or foreign country) <u>Queen Ann C. Md.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Smoking</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>W.W. II</u>		16. SOCIAL SECURITY No. <u>217-16-9295</u>	
17. INFORMANT AND ADDRESS <u>Mr. Joseph Wilson - Barclay Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <u>202.1</u> (a) <u>Malignant lymphoma</u>			<u>6 months</u>
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>Other significant conditions</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr 23, 1955</u> to <u>July 16, 1955</u> , that I last saw the deceased alive on <u>July 12, 1955</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Edgar D. Kane</u> (Degree or title)		ADDRESS <u>Willington Md.</u> DATE SIGNED <u>7-18-55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>July 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Barclay County</u> LOCATION (City, town, or county) <u>Barclay Maryland</u> (State)	
DATE REC'D BY LOCAL REG. <u>7-18</u> REGISTRAR'S SIGNATURE <u>Edgar D. Kane</u>		24. FUNERAL DIRECTOR <u>Marion V. Wallis</u> ADDRESS <u>Chesapeake Md</u>	

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